MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1146 09600

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7
Hospital, institution, or street address where death occurred: Charlestown St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Charlestown St
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Jno. H. Beeman

3.(b) Social Security Number: 216-07-2792

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Melvina A. Salisbury Beeman
6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): Aug. 11, 1873

8. AGE: Years: 74 | Months: 8 | Days: 3 | If less than one day: ...hrs. ...min.

9. Birthplace: Lonaconing Allegany Co Md (Town, county, and state)
10. Usual occupation: Coal Miner - Retired
11. Industry or business:

FATHER
12. Name: Henry Beeman
13. Birthplace: Lonaconing

MOTHER
14. Maiden name: Charlotte Dye
15. Birthplace: Lonaconing (Charlestown)

16. Informant: Mrs. Ed Beeman
Address: Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 17 1947 (month) (day) (year)
Cemetery or crematory: Dye Cemetery
Location: Lonaconing, Md

18. Funeral director: M. Eichhorn
Address: Lonaconing, Md

19. Nov 17 1947 (Date rec'd by registrar) Jeannette M Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14th 1947, at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 23 1947, to Nov 14 1947
and that I last saw h. A.M. alive on Nov. 14 1947

Immediate cause of death: Anthracosis with asthma — DURATION:
Due to: /
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work?

23. SIGNATURE: Paul Eugene Drye M.D.
M. D. or other
Address: Lonaconing, Md. Date signed: 11/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4/6d

CERTIFICATE OF DEATH

09601 9
Reg. Dist. No.

1. PLACE OF DEATH:
County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, Institution, or street address where death occurred:
80 E. Mechanic St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 80 E. Mechanic St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Bessie Ann Bender

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Bruce Bender
6.(c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) Aug. 8 Th. 1888

8. AGE: Years	Months	Days	If less than one day
59	8	8	hrs. min.

9. Birthplace Garrette Co. Frostburg, Md (Town, county, and state)
10. Usual occupation Housework
11. Industry or business
12. FATHER Name Jacob McKenzie
13. Birthplace Garrette Co. Md.
14. MOTHER Maiden name Emma Crutcher
15. Birthplace Garrette Co. Md.
16. Informant Marshall McKenzie
Address R.D. No 1 Lonaconing Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 15 1947 (month) (day) (year)
Cemetery or crematory St. Cumas
Location Oakland Md.
18. Funeral director Jacob Bafus
Address Frostburg Md.
19. 11-14 1947 Mrs Hawley H. Rae Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1947, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 1946, to November 12 1947 and that I last saw h alive on November 12 1947.

Immediate cause of death	DURATION
Carcinoma of rectum.	1½ yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. C. Diehl, M. D.
M. D. or other
Address Frostburg, Md. Date signed 11/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor's signature is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Diehl 46d 09602

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred: Miners' Hospital

How long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Eckhart

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Cleaber Clifford Bennett

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Josephine Bennett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 18, 1867

8. AGE:

Years	Months	Days	If less than one day
80	9	1	..... hrs. ..... min.

9. Birthplace: Eckhart, Allegany, Md.

(Town, county, and state)

10. Usual occupation: retired

11. Industry or business: mail carrier

FATHER

12. Name: Charles Bennett

13. Birthplace: Maryland

MOTHER

14. Maiden name: unknown

15. Birthplace: "

16. Informant: Mrs. Emma Twigg

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 22 1947 (month) (day) (year)

Cemetery or crematory: Porter Cemetery

Location: Eckhart Md.

18. Funeral director: J. R. Dirst

Address: Frostburg Md.

19. 11-21 1947 Mrs. Nancy N. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19 1947, at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946, to Nov. 19 1947

and that I last saw h[illegible] alive on November 19 1947.

Immediate cause of death	DURATION
Carcinoma of rectum	1½ yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. C. Diehl, M. D.

M. D. or other

Address: Frostburg, Md. Date signed 11/24/47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46g

09603

Reg. Dist. No. 2

1. PLACE OF DEATH:

County: Allegany

City or town: Little Orleans, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years

~~Hospital~~, Institution, or street address where death occurred: R.F.D. 1.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Little Orleans, (rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. 1.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Jessie Alletta Boden

3.(b) Social Security Number: —

4. Sex: F

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: M. F. Boden

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Sept. 7, 1876

8. AGE: Years: 71 | Months: 1 | Days: 27 | If less than one day: — hrs. — min.

9. Birthplace: Fulton Co. Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: Joseph B. Smith
13. Birthplace: Bedford Co., Pa.

MOTHER
14. Maiden name: Elizabeth A. Smith
15. Birthplace: Bedford Co., Pa.

16. Informant: M. F. Boden

Address: Little Orleans, Md. R.I.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 7, 1947 (month) (day) (year)

Cemetery or crematory: Christian Cemetery

Location: Buck Valley, Pa.

18. Funeral director: Ephraim Smith

Address: Artemas, Pa.

19. Nov. 5 1947 (Date rec'd by registrar) Nina L. Bender, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4 1947, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947, to Nov. 4, 1947 and that I last saw her alive on Nov. 3, 1947

Immediate cause of death	DURATION
Carcinomatosis	2 wks.
Due to: Carcinoma of the pancreas	7 mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work?

23. SIGNATURE: J. A. Watson, M.D.
M. D. or other

Address: Little Orleans, Md. Date signed: 11/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

Reg. Dist. No. 096040

1. PLACE OF DEATH:
County: Allegany
City or town: Rural Mt Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, Institution, or street address where death occurred:
Bald Knob.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural Mt Savage.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bald Knob.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lawrence Brailer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 13 1859

8. AGE: Years: 88 | Months: 6 | Days: 15 | If less than one day: hrs: min.

9. Birthplace: Somerset Co Pa.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Augustus Brailer
13. Birthplace: Germany

MOTHER
14. Maiden name: Cecilia Lodgson
15. Birthplace: Pa.

16. Interment: Miss Rose Brailer
Address: Mt Savage Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 1 - 47 (month) (day) (year)
Cemetery or crematory: St Patricks Cem.
Location: Mt Savage Md

18. Funeral director: Lord & Stein Inc
Address: Cumberland Md.

19. Nov 29 1947 (Date rec'd by registrar) Vernice McDermitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 28 1947 at 145 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to Nov 28 1947 and that I last saw h[illegible] alive on Nov 25 1947

Immediate cause of death	DURATION
(a) Uremia Cystitis	one year
Due to: (b) Chronic Myocarditis	2 yrs
Due to: (c) Chronic Arthritis	15 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

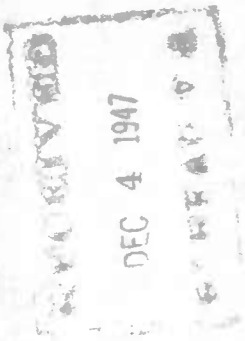
23. SIGNATURE: F. Alan G. Hunn M. D. or other
Address: Cumberland Md. Date signed: Nov 29 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr F. A. J. Murray.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

58C 09605

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH:

County: Allegany

City or town: near Cumberland Md., Amcelle Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Celanese Corp. Of Am.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Christy Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Harry W. Bramble Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Nina Oura Bramble

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 11, 1911

8. AGE: Years	Months	Days	If less than one day
35	11	23	..... hrs. ..... min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Spinner

11. Industry or business: Celanese Corp.

FATHER
12. Name: Luther S. Bramble
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Hattie Wadsworth
15. Birthplace: Berlin, Penna.

16. Informant: Mrs. Nina Bramble
Address: R.D.#4 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 26, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Herman Cem.

Location: Near Cumberland, Md.

19. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Nov. 25 1947 (Date rec'd by registrar) M. D. Tennant Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24 19 47 at 6.25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead Nov. 24 19 47

Immediate cause of death: Rheumatic endocarditis — DURATION: about 1 year

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Deputy Medical Examiner Injured at work? Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M. D. Coroner

Address: Cumberland Md. Date signed: 11-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

09606

CERTIFICATE OF DEATH

Reg. Dist. No. 2

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Allegany

City or town (rural) Route 2 [redacted] Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Mar Twiggtown, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town (rural) Route 2 Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Williams Rd. near Twiggtown Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Laura Christine Rice Brown

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife Alonzo Brown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1876

8. AGE: Years	Months	Days	If less than one day
71	2	8	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany Co. Md.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At home

FATHER 12. Name John Rice

13. Birthplace Cumberland Md

MOTHER 14. Maiden name [illegible] ?

15. Birthplace [illegible]

16. Informant Mrs. Raymond Brown

Address Rt. 2, Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 1 1947 (month) (day) (year)

Cemetery or crematory Rite Cemetery

Location Mar Cumberland

18. Funeral director John Hafer

Address Cumberland Md

19. Dec. 2, 1947 (Date rec'd by registrar) Nina L. Bender Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1947 at 9.30P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw her alive on Dead Nov. 28 1947

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to arteriosclerosis	
Due to	
Other conditions hypertention	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.

M. D. or other

Address Cumberland Md. Date signed 11-28-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

169

09607

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Eastbound Yards Of B&O R.R.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 711 Louisana Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Hugh G. Bryant

3.(b) Social Security Number: 705-07-9700

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Bertha Cheshire

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 30, 1887

8. AGE: Years	Months	Days	If less than one day
60	7	21	..... hrs. ..... min.

9. Birthplace: Savage, Virginia (Town, county, and state)

10. Usual occupation: Yard Conductor

11. Industry or business: B & O R.R.

FATHER 12. Name: Cristopher C. Bryant

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Mary Emma Perkinson

MOTHER 15. Birthplace: Virginia

16. Informant: Mrs. Hugh G. Bryant

Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 24, 1947 (month) (day) (year)

Cemetery or crematory: Hillcreast Burial Park

Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Nov 24 1947 (Date rec'd by registrar) W.R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 21 1947 at 3.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him Dead Nov. 21 1947

Immediate cause of death	DURATION
Exsanguination	at once
Due to: Body severed through chest	
right arm severed at shoulder	
Due to: ran over by R.Ry engine	
Other conditions: Fractured nose, fingers on left hand lacerated	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 11-21-47

Where did injury occur? B&O R.Ry Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?): East bound yards B&O R.Ry.

Means of injury: Ran over by engine Injured at work? yes

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V. Deming M.D. H.V. Deming M.D.
M. D. or [illegible]

Address: Cumberland Md. Date signed: 11-21-47

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46e

09668

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 Years

Hospital, Institution, or street address where death occurred:
Rt 4 Box 383, Cumberland, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt 4, Box383
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Alice Buckley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Aldon Buckley

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): September 26 1895

8. AGE: Years	Months	Days	If less than one day
52	1	24	..... hrs. ..... min.

9. Birthplace: Brandyville, Preston Co, W.Va.
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER 12. Name: Camdon Deberry

13. Birthplace: West Virginia

MOTHER 14. Maiden name: Anne Vansickle

15. Birthplace: West Virginia

16. Informant: Aldon Buckley

Address: Rt 4, Box 383, Cumberland, Md.

17. (Burial, cremation, or removal. Which?) Date thereof: 11/22/47 (month) (day) (year)

Cemetery or crematory: St Lukes Cemetery

Location: Glebe, W. Va.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Nov 21, 19 47 (Date rec'd by registrar) W.R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20 19 47 at 12-01A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 19 47 to Nov. 20 19 47 and that I last saw h er alive on November 6 19 47

Immediate cause of death	DURATION
Carcinoma of Ascendens and Transv	2
Due to Colon, Liver Metastases	*
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma Colon Date of op. Sept 5, 1947

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel Jarboe M. D. or other

Address: 17 Bosley St Date signed: 11/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09609

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 93 W. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 93 W. Main

(If rural, give LOCATION)

2.(a) If veteran, name war: 1st World War

3. (a) FULL NAME: John Craze

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 15, 1888

8. AGE: Years	Months	Days	If less than one day
59	5	7	____ hrs. ____ min.

9. Birthplace: York — Pa. (Town, county, and state)

10. Usual occupation: Coal miner

11. Industry or business: unable to work

FATHER

12. Name: Wm. H. Craze

13. Birthplace: England

MOTHER

14. Maiden name: Mary Bond

15. Birthplace: England

16. Informant: Sidney Craze

Address: Frostburg, Md.

17. Burial (Burial, cremation, or Removal. Which?) Date thereof Nov 25-1947 (month) (day) (year)

Cemetery or ~~cremetery~~: Allegany

Location: Frostburg, Md.

18. Funeral director: J. E. Dumpt

Address: Frostburg, Md.

19. 11-25 (Date rec'd by registrar) 1947 Mrs. Dawley V. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 22 1947, at 8 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to Nov 22 1947

and that I last saw him alive on Nov 22 1947

Immediate cause of death	DURATION
Chronic Myocarditis	5 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: W. M. McLane M.D. M. D. or other

Address: Frostburg Md Date signed 11-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93 e

09610

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 8 years

Hospital, Institution, or street address where death occurred: Railroad Street

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No. Railroad St. (If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Janet Pollock Creighton

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Robert Creighton

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Mar. 14, 1860

8. AGE: Years	Months	Days	If less than one day
87	7	18	...hrs. ...min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER — 12. Name: Pollock

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Janet Laird

MOTHER — 15. Birthplace: Scotland

16. Informant: Mrs. John Smith

Address: Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 4 1947 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. Nov 4 1947 (Date rec'd by registrar) Janette M Beal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 2 1947 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-47 19... to 11/1 19.47

and that I last saw h.e.r. alive on 11/1/47 19...

Immediate cause of death: Congestive Heart Failure — DURATION

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. ...

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Paul Eugene Drye M.D. (M.D. or other)

Address: Lonaconing, Md. Date signed: 11/4/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09611

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, Institution, or street address where death occurred:

109 N. Spruce St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 N. Spruce St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Deborah Ann Davis

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1947

8. AGE: Years	Months	Days	If less than one day
0	4	19	hrs. min.

9. Birthplace Cumberland, Allegany, Md.

(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER

12. Name Giltroy Davis

13. Birthplace Cumberland, Md.

MOTHER

14. Maiden name Doris Frisby

15. Birthplace Frostburg, Md.

16. Informant Giltroy Davis

Address 109 N. Spruce St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 3 1947 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Nov. 3 1947 (Date rec'd by registrar) Wm. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1947 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 30 1947 to Nov. 1 1947

and that I last saw he alive on Nov. 1 1947

Immediate cause of death	DURATION
Lobar Pneumonia	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Lobar Pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. L. Hodges M. D. or other

Address Cumberland, Md. Date signed 11/2/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d

09612

Reg. Dist. No. 14

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Ellerslie
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Ellerslie
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Emory Diehl

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Jennie Smith

7. Birth date of deceased (mo., day, yr.) December 25, 1873 — 6.(c) If alive, give age 73 years

8. AGE: Years	Months	Days	If less than one day
73	-		hrs. min.

9. Birthplace Bedford Pa. RFD #4
(Town, county, and state)

10. Usual occupation Prr Hostler

11. Industry or business P. R.R.

FATHER 12. Name John Diehl

FATHER 13. Birthplace Penna.

MOTHER 14. Maiden name Kathryn Whestone

MOTHER 15. Birthplace Penna.

16. Informant Bruce Diehl

Address Corriganville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/ 20/ 1947 (month) (day) (year)

Cemetery or crematory Cove Reformed Cemetery

Location Bedford Pa. RFD # 4

18. Funeral director Harvey H. Zeigler

Address Hyndman, Pa.

19. Nov 20 1947 (Date rec'd by registrar) J. Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 • 1947 at 12.00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to 11-18-1947 and that I last saw h[illegible] alive on 11-18-1947

Immediate cause of death	DURATION
Chronic Myocarditis	15 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A Lapper M.D. M. D. or other

Address Hyndman Pa Date signed 11/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09613

CERTIFICATE OF DEATH

Reg. Diat. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Reeves Clinic

How long in hospital or Institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: XXXXXXX Md. County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 Philos Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: SARAH CATHERINE DYER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William C. Dyer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 28, 1884

8. AGE: Years	Months	Days	If less than one day
63	9	8	..... hrs. ..... min.

9. Birthplace: Westernport, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own home

FATHER

12. Name: John T. Spriggs

13. Birthplace: Pennsylvania

MOTHER

14. Maiden name: Augusta L. Ross

15. Birthplace: Cross, W. Va.

16. Informant: Mrs William Russell

Address: Westernport, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 9, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Western ort, Md.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md.

19. Nov 8 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6 19 47 at 11:00a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/6/47 19.. to 11/6 19 47 and that I last saw h.. alive on 11/6/47 19..

Immediate cause of death	DURATION
Cerebral Haemorrhage	1 hr.
Due to Hypertension — Vascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: [signature] M. D.

M.D. or other

Address: Westernport Md. Date signed 11/6/47

Within corporate limits

SCHINDLER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

938

09614

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 329 FERDERICK STREET
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
EDMONSON, LUCY ANN

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	COLORED	MARRIED

6.(b) Name of husband or wife EDMONSON, SAMUEL
6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) January 19, 1886

8. AGE: Years	Months	Days	If less than one day
61	10	0	hrs. min.

9. Birthplace [redacted], [redacted] Success, Va.
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name TIGNEY, JOSEPH
13. Birthplace VIRGINIA

MOTHER
14. Maiden name HALE, ANNIE
15. Birthplace VIRGINIA

16. Informant Samuel Edmonson
Address 329 Frederick St, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof November 22, 1947 (month) (day) (year)

Cemetery or crematory Sumner Cemetery
Location Cumberland, Md

18. Funeral director John J. Hafer
Address Cumberland, Md.

19. Nov 22 47 (Date rec'd by registrar) Hunter R. Scott M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 19 1947 at 4:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 1947, to Nov. 19 1947, and that I last saw h[illegible] alive on Nov. 19 1947.

Immediate cause of death	DURATION
Hypertensive C.V. Disease	Years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. M. Schmeiler M.D.
M. D. or other
Address 46 Grant St Date signed Nov 24, 1947

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

09615

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 9 mos.

Hospital, institution, or street address where death occurred: Allegany County Infirmary

How long in hospital or institution? 1 yr. 9 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.: West Main St. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Leopold Eichhorn

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Annie Lockner Eichhorn

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct. 20, 1862

8. AGE: Years: 85 | Months: 1 | Days: 6 | If less than one day: ... hrs. ... min.

9. Birthplace: Frostburg, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Cabinet maker / Retired

11. Industry or business: Own Shop

FATHER — 12. Name: August Eichhorn

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Frederika Shaffer

MOTHER — 15. Birthplace: Germany

16. Informant: Family Record — Address: M. Eichhorn - Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 28, 1947 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. Nov. 28, 1947 (Date rec'd by registrar) — Walter R. Trout M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26, 1947 at 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to Nov. 26 1947

and that I last saw him alive on Nov 25 1947

	DURATION
Immediate cause of death: Coronary Occlusion	6 hrs.
Due to: Generalized arteriosclerosis	12 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 110 S. Centre St. Date signed: 11-28-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09616

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? Allegany 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Bedford
City or town: Hyndman, Pa.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: George H. Emerick

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Ellen Wilhelm
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Jan 16 1880

8. AGE: Years	Months	Days	If less than one day
67	10	8	hrs. min.

9. Birthplace: Gladdens Bedford County, Penna.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Solomon Emerick
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Mary Ellen Albright
15. Birthplace: Pennsylvania

16. Informant: Russell Emerick
Address: Hyndman, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/27/47 (month) (day) (year)
Cemetery or crematory: Palo Alto
Location: Hyndman, Pa.

18. Funeral director: Harvey H. Zeigler
Address: Hyndman, Pa.

19. Nov 26 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24 1947, at 4pm M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1940, to Nov 24 1947
and that I last saw h... alive on Nov 24 1947

Immediate cause of death	DURATION
Carcinoma Stomach	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John A Toppen MD M. D. or other
Address: Hyndman Pa Date signed: 11/25/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13(a)

09617

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Standish St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Laurence Lee Feldmann

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 10, 1886

8. AGE:

Years	Months	Days	If less than one day
61	2	25	..... hrs. ..... min.

9. Birthplace Eckhart Allegany Md.

(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Peter Feldmann

13. Birthplace Germany

MOTHER 14. Maiden name Mary Farley

15. Birthplace Maryland

16. Informant Miss Lillian Feldman

Address Eckhart Md.

17. Burial (Burial, cremation, or removal Which?) Date thereof Nov. 8 1947 (month) (day) (year)

Cemetery or crematory St. Michaels

Location Frostburg Md.

18. Funeral director J. R. Hirst

Address Frostburg Md.

19. 11-7 1947 Mrs. Nancy K Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1947 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 29 1947 to Nov 5 1947

and that I last saw h.M. alive on Nov 5 1947

Immediate cause of death Cardio-Vascular Renal Disease

	DURATION
Due to	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. E. Gattens M.D.

M. D. or other

Address Frostburg Md. Date signed 11/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09618

82a

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegheny

City or town: Frostburg, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Meneis Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 wks

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna County: Somerset

City or town: Confluence, Pa Rd 2 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Isabell Fick

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

B (b) Name of husband or wife: John Fick

6(c) If alive, give age: 85 years

7. Birth date of deceased (mo., day, yr.): February 18, 1874

8. AGE:

Years	Months	Days	If less than one day
73	8	18	hrs. min.

9. Birthplace: Sheffield England
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Fred Dickerson
13. Birthplace: Sheffield England

MOTHER
14. Maiden name: Ellen Cartright
15. Birthplace: Sheffield, England

16. Informant: John C. Fountain

Address: Confluence, Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 9, 1947 (month) (day) (year)

Cemetery or crematory: Addison Cemetry

Location: Addison, Penna

18. Funeral director: H.B. Rushenberger

Address: Addison, Pa

19. 11-8-1947 (Date rec'd by registrar) Mrs Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 6 1947, at 1:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 29 1947, to Nov 6 1947, and that I last saw her alive on Nov 6 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 wks
Left Hemiplegia	
Due to: Hypertension	7 ?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W O Crane MD
M. D. or other

Address: Frostburg Md Date signed 11-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a

Dr McLane

09619

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 268 E Main St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Francis A. Flanagan

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widowed

6.(b) Name of husband or wife: Katherine Flanagan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 7, 1868

8. AGE: Years	Months	Days	If less than one day
79	8	18	..... hrs. ..... min.

9. Birthplace: Indiana (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal mines

FATHER — 12. Name: John Flanagan

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Margaret Treal

MOTHER — 15. Birthplace: Kentucky

16. Informant: Lourdine Flanagan

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 29 1947 (month) (day) (year)

Cemetery or crematory: St. Michael's Cemetery

Location: Frostburg Md

18. Funeral director: C. J. Durst

Address: Frostburg Md

19. 11-28-47 Mrs. Lady X. Rae Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 26 1947, at 2.35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 2 1947 to Nov 26 1947 and that I last saw h alive on Nov 26 1947

Immediate cause of death	DURATION
Senility	
Due to Bronchopneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. M. Lane M.D. M. D. or other

Address: Frostburg Md Date signed 11-27-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159 S 09620

Reg. Dist. No. 4

1. PLACE OF DEATH

County: ALLEGANY

City or town: CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: WEST VIRGINIA County: GRANT

City or town: MAYSVILLE (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

BABY BOY FRANZ (PREMATURE)

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): NOV. 28, 1947 @ 10:23 P.M.

8. AGE: Years	Months	Days	If less than one day
N.B.			8 hrs. 2 min.

9. Birthplace: MEMORIAL HOSPITAL Cumberland, Allegany Co., Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: EDWARD D. FRANZ

13. Birthplace: WEST VIRGINIA

MOTHER

14. Maiden name: CLARICE WEES

15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL

Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 30 1947 (month) (day) (year)

Cemetery or crematory: Franz Family Cem

Location: Maysville, W. Va.

18. Funeral director: P. C. Thackerson

Address: Petersburg W Va

19. Nov 29 1947 (Date rec'd by registrar) W. R. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOVEMBER 29, 1947 6:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 29 1947 to Nov. 29 1947 and that I last saw him alive on Nov. 29 1947

Immediate cause of death: Prematurity — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W R Hodges M. D. or other

Address: Cumberland Md Date signed: 11/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83d 09621

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md. 107 Blaul Ave.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:
107 Blaul Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 107 Blaul Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Balser Garland

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mahulda Beck — 6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Jan. 6- ~~1864~~ 1865

8. AGE: Years	Months	Days	If less than one day
82 ~~83~~	10	18	hrs. min.

9. Birthplace: Fulton County, Pennsylvania
(Town, county, and state)

10. Usual occupation: Laborer - Retired

11. Industry or business: Western Md. R. R. Co.

FATHER — 12. Name:

13. Birthplace: Unknown

MOTHER — 14. Maiden name:

15. Birthplace:

16. Informant: Mrs. Balser Garland

Address: 107 Blaul Ave. City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 26, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Tabor Methodist Cem

Location: Near Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Nov. 26 1947 (Date rec'd by registrar) W. H. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24 19 47 at 2.30P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive Dead Nov. 24 19 47

Immediate cause of death	DURATION
Cardiac paralysis	at once
Due to: hemiplegia	2 weeks
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of Injury: ... Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H.V.Deming M.D. H.V.Deming M.D. M. D. or other

Address: Cumberland Md. Date signed: 11-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09622

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 51 Years

Hospital, Institution, or street address where death occurred:

Park Heights R.F.D # 6

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Park Heights, R.F.D. # 6

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Clarence Maclay Gearhart

3. (b) Social Security Number: 705-05-8195

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah Mellinger Gearhart — 6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): March 10 1873

8. AGE: Years	Months	Days	If less than one day
74	8	5	...hrs. ...min.

9. Birthplace: Sunbury, North Thumberland, Penna (Town, county, and state)

10. Usual occupation: Hill Superviser

11. Industry or business: Baltimore & Ohio Railroad

FATHER — 12. Name: Maclay Gearhart

FATHER — 13. Birthplace: Sunbury, Pa

MOTHER — 14. Maiden name: Rosana Gossler

MOTHER — 15. Birthplace: Sunbury, Pa.

16. Informant: Mrs Sarah Gearhart

Address: Park Heights R.F.D.# 6, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 18, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Nov. 18 1947 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15 1947, at 12-45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 3 1947 to Nov 15 1947

aed that I last saw h... alive on November 14 1947

Immediate cause of death: Hypostatic congestion & R Lung — DURATION: 2 days

Due to: Injury & shock — received Nov 2 hospital

Due to: 4 Rib Fx Left sides Pneumothorax & collapse Nov 2 47

Other conditions: L. Lung

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of Nov 2 47

Where did injury occur? Cumberland Allegany Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Yards

Means of Injury: Fell from a ladder Injured at work? Yes

23. SIGNATURE: [signature] M. D. or other

Address: Cumberland Md Date signed: Nov 15 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctage is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09623

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 12 Laing Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ronald Edwin Gibson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 13 1947

8. AGE:

Years	Months	Days	If less than one day
	4	26	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Harold Gibson
13. Birthplace: Wheeling, W. Va.

MOTHER
14. Maiden name: Betty Keplinger
15. Birthplace: Cumberland, Md

16. Informant: Harold Gibson
Address: 12 Laing Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/12/47 (month) (day) (year)
Cemetery or crematory: Zion Memorial Park Cemetery
Location: Cumberland, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. Nov. 12, 19 47 (Date rec'd by registrar) W. L. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 - 9 19 47 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-8 19 47 to 11-9-19 47 and that I last saw h... alive on 11-8 - 19 47

	DURATION
Immediate cause of death: bronchopneumonia	2 days
Due to: peritonitis	2 week
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. Wrenn (M.D.) M. D. or other

Address: 59 Greene St. Date signed: 11-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr McLane

61

09624

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 101 Walnut St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Annie Greening

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Greening
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 23 1894

8. AGE: Years	Months	Days	If less than one day
53	9	1	..... hrs. ..... min.

9. Birthplace: Frostburg Allegany Md.
(Town, county and state)
10. Usual occupation: housewife
11. Industry or business: home

FATHER
12. Name: Charles Thomas
13. Birthplace: Wales

MOTHER
14. Maiden name: Emily Whitney
15. Birthplace: Pennsylvania

16. Informant: Mrs Raymond Greening
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-28-47 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md.

18. Funeral director: J. R. Durst
Address: Frostburg Md.

19. 11-28 1947 Mrs. Henry A. Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 25 1947, at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 19.. to Nov 25 1947
and that I last saw her alive on Nov 25 1947

Immediate cause of death	DURATION
Coronary Thrombosis	10 Day
Due to: Diabetes	several years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Wm McLane MD
M. D. or other
Address: Frostburg Md Date signed 11-26-47

Within corporate limits

Steve 27

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

117a

09625

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 938 Maryland Ave. (If rural, give LOCATION)

2.(a) If veteran, name war World War II

3. (a) FULL NAME Claude Duvall Grove

3. (b) Social Security Number 219-03-8915

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Charlotte V. Grove

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 18 1919

8. AGE:

Years	Months	Days	If less than one day
28	4	29	..... hrs. ..... min.

9. Birthplace Martinsburg Berkeley Co. W. Va.

(Town, county, and state)

10. Usual occupation Machine Operator

11. Industry or business Celanese Corp. of America

FATHER 12. Name Boyd Grove

13. Birthplace West Virginia

MOTHER 14. Maiden name Elsie Dilley

15. Birthplace West Virginia

16. Informant Boyd E. Grove

Address 938 Md. Ave., Cumberland, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 16, 1947 (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery

Location Cumberland, Md.

18. Funeral director Long & Stein, Inc.

Address Cumberland, Md.

19. Nov 15, 1947 (Date rec'd by registrar) W. R. Fantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1947 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-4- 1947, to 11-12- 1947, and that I last saw him alive on 11-12- 1947

Immediate cause of death	DURATION
pancreatitis	6 days
Due to	
Due to	
Other conditions Chronic Tonsilitis	1 year

(Include pregnancy within 3 months of death) Surgical

Major findings of operation pancreas swollen Date of op. 11-4-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

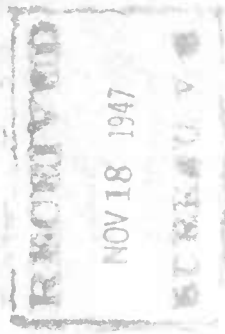
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Kline M.D. M. D. or other

Address 59 Greene St. Date signed 11-19-47

Dr Lewis Briggs



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

09626

Reg. Dist. No. 4

Lester

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution or street address where death occurred: 116 S. Mechanic St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 116 S. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martha Ellen Harbaugh.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Lewis Francis Harbaugh

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 9 1856

8. AGE: Years	Months	Days	If less than one day
91	6	4	____ hrs. ____ min.

9. Birthplace Near Baltimore, Pa.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home.

FATHER

12. Name Michael Hickey

13. Birthplace Washington D. C.

MOTHER

14. Maiden name Margaret Bridge

15. Birthplace Unknown

16. Informant Miss Ella Harbaugh

Address Cumberland

17. Burial Date thereof Nov 15 47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peter + Paul's Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Nov 14 1947 W. R. Beauty M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1947 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to Nov 13 1947

and that I last saw h[illegible] alive on Nov 13 1947

Immediate cause of death Myocardial degeneration ____ DURATION

Due to Senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. K. Lester M. D. or other

Address 122 Bedford St Date signed 11/13/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Diat. No. 09627 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo

Hospital, Institution, or street address where death occurred:

203 Wilmont Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State N. Y. County N. Y.

City or town New York City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 545 W. 148th St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Margaret Maisch Harrat

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Frank Turner Harrat

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr 1, 1876

8. AGE: Years	Months	Days	If less than one day
71	7	9	..... hrs. ..... min.

9. Birthplace New York City, N.Y.Co. N.Y.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER 12. Name Gottfried Maisch

13. Birthplace Germany

MOTHER 14. Maiden name Unknown

15. Birthplace Bavaria

16. Informant Mr Frank Harrat

Address Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 13, 1947 (month) (day) (year)

Cemetery or crematory Trinity Parish Cemetery

Location 155th & Broadway - N.Y. City.

18. Funeral director John J Hofer

Address Cumberland Md.

19. Nov 11 1947 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1947 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept - 1 1947 to Nov 10 1947 and that I last saw h[illegible] alive on Nov - 7 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to (Dead on Arrival 11/10/47)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. Mauriello M.D. M. D. or other

Address 44 Greene ST Date signed 11/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13/a

09628

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 52 Yrs 9 Mo 19 Days
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 9 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 218 DAVIDSON STREET
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
MISS BESSIE HARRISON

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JANUARY 25, 1895

8. AGE: Years	Months	Days	If less than one day
52	9	18	..... hrs. ..... min.

9. Birthplace MARYLAND, Cumberland
(Town, county, and state)
10. Usual occupation PUBLIC STENOGRAPHER
11. Industry or business

FATHER
12. Name WILLIAM HARRISON
13. Birthplace MARYLAND

MOTHER
14. Maiden name HEUBNER, ELIZABETH
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND

17. Burial Date thereof 11/16/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenmount Hill Cemetery
Location Cumberland, Md.
18. Funeral director William H. Kight
Address Cumberland, Md.

19. Nov 16, 1947 W. R. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13-1947 at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3rd 1947 to 11-13-1947 and that I last saw h[illegible] alive on 11-13-1947

Immediate cause of death	DURATION
Cardio vascular Renal disease	5 Mos.
Due to Pneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other
Address Cumberland Md. Date signed 11-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09629

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 - 7 - 15

Hospital, Institution, or street address where death occurred: 103 Bedford St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 103 Bedford St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Henry Hast

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Blanche T. Baer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 21 1874

8. AGE: Years	Months	Days	If less than one day
73	7	15	..... hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Shipchandler

11. Industry or business: Fish Market

FATHER — 12. Name: Henry Hast

13. Birthplace: Md.

MOTHER — 14. Maiden name: Mary C Berg

15. Birthplace: Md.

16. Informant: Mrs W. H. Hast

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 9 47 (month) (day) (year)

Cemetery or crematory: St Peter & Paul Cem

Location: Cumberland

18. Funeral director: Louis Stein Son

Address: Cumberland

19. Nov. 8, 1947 (Date rec'd by registrar) Wm. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6 1947 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to November 6 1947

and that I last saw him alive on November 6 1947

Immediate cause of death	DURATION
Myocardial Infarction	3 hours
Coronary occlusion	
Due to: Arteriosclerotic heart disease	2
Due to:	
Other conditions: Duodenal ulcer	40 years

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of: No

Where did injury occur? No (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) No

Means of injury: No Injured at work? No

23. SIGNATURE: Lewell G. Wesaman M.D. M. D. or other

Address: 122 Bedford St Date signed: 11/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits Dr. Van Ormer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92C

CERTIFICATE OF DEATH

Reg. Dist. No. 09630 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital, Cumberland, Md.
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Grantsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war V

3.(a) FULL NAME Miss Josephine Hone

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1897

8. AGE: Years	Months	Days	If less than one day
50			hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name William Hone
13. Birthplace Maryland

MOTHER
14. Maiden name Laura Hone
15. Birthplace Maryland

16. Informant Memorial Hospital
Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 27 1947 (month) (day) (year)
Cemetery or crematory Hopes
Location Hopes Cem
18. Funeral director Wm. M. Turney
Address Grantsville Md

19. Nov. 24 1947 (Date rec'd by registrar) W. L. Fauntz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1947 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1 Sept 47 to 23 Nov. 47
and that I last saw h... alive on 23 Nov 47

Immediate cause of death	DURATION
Valvular Heart Disease, Chronic Rheumatic origin with Coronal Coronic failure.	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Alfred Van Ormer M. D. or other
Address Cumberland Md Date signed 24 Nov 47

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83e

09631

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in correct... It is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Braddock Farms near Cumb
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred: Maryland St. Route #1-
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Braddock Farms near Cumb
(If outside city or town limits, write RURAL and give nearest town)
Street No. Maryland St, Route #1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Amos Lee Hughes

3.(b) Social Security Number 214-10-5339

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Rosella Brant
6.(c) If alive, give age 49 years
7. Birth date of deceased (mo., day, yr.) Sept 29, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	4	hrs. min.

9. Birthplace Hancock Washington Co, Md
(Town, county, and state)
10. Usual occupation Lineman
11. Industry or business Potomac Edison Co.

FATHER
12. Name John Hughes
13. Birthplace Hancock, Md.

MOTHER
14. Maiden name Serena ?
15. Birthplace Hancock Md

16. Informant Mrs Amos Lee Hughes
Address Braddock Farms Rt 1 Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof November 6, 1947 (month) (day) (year)
Cemetery or crematory Hillcrest Cemetery
Location Cumberland, Md
18. Funeral director John J. Hofer
Address Cumberland, Md.

19. Nov. 6, 1947 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1947, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Nov 3 1947
and that I last saw him alive on Nov 3 1947

Immediate cause of death Cerebral Thrombosis — DURATION 2 days
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work

23. SIGNATURE [illegible] M.D. M. D. or other
Address 404 Decatur St Cumberland Md Date signed 11/6/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09632

469

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 207 Washington St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ida Cordelia Johnson

3.(b) Social Security Number: none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed.

6.(b) Name of husband or wife: Jas T Johnson Sr.

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 29 1876

8. AGE: Years: 71 | Months: 6 | Days: 29 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Leeds Pt N.J.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Job Mathis
13. Birthplace: N.J.

MOTHER
14. Maiden name: Mary Carter
15. Birthplace: N.J.

16. Informant: Dr Jas T. Johnson Jr.
Address: Cumberland.

17. Burial & Remove Date thereof: Dec 30 47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Florence, Alabama
Location: " "

18. Funeral director: Gonis Stein & Sons
Address: Cumberland

19. Dec 29 1947 W.L. Faught M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 28 1947, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 23 1947 to November 28 1947 and that I last saw h alive on November 28 1947

	DURATION
Immediate cause of death: Hepato-renal failure	5 days
Due to: obstructive jaundice	5 days
Due to: Carcinoma of head of pancreas, unknown obstructing common bile duct	?
Other conditions: arteriosclerotic heart disease	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: no Date of op.: no

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of: no

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): no

Means of injury: Injured at work? no

23. SIGNATURE: J.G. Weesman MD
M. D. or other

Address: 122 Bedford St Date signed: 11/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

09633

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 201 Rock Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 201 Rock Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: WILLIAM HOWARD KEARNS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hazel Kearns
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): December 22, 1883

8. AGE: Years	Months	Days	If less than one day
63	10	26	hrs. min.

9. Birthplace: Westernport, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: Grocery Store

FATHER
12. Name: John Kearns
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Sarah K. Michaels
15. Birthplace: Westernport, Maryland

16. Informant: Mrs Hazel Kearns
Address: Westernport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 22, 1947 (month) (day) (year)
Cemetery or crematory: Philos Cemetery
Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal
Address: Westernport, Maryland

19. Nov. 20 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18, 1947 at 8:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Nov 18 1947 and that I last saw him alive on Nov 18 1947

Immediate cause of death	DURATION
Coronary Occlusion	6 wks
Due to Coronary sclerosis	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas Reese, M. D
M. D. or other
Address: Westernport Md Date signed 11-20-47

Within corporate limits of Cumberland

No certificate

160c

09634

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 HOURS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 11 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town OAKLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME

KEMPHFER, BABY BOY

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	INFANT

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 21, 1947

8. AGE:

Years	Months	Days	If less than one day
			11 hrs. ..... min.

9. Birthplace CUMBERLAND, ALLEGANY, MARYLAND
(Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name HARLAND KEMPHFER

13. Birthplace MARYLAND

MOTHER
14. Maiden name LILLIAN KISER

15. Birthplace MARYLAND

16. Informant Harland Kemphfer

Address Mt. Lake Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 23 1947 (month) (day) (year)

Cemetery or crematory Oakland Cemetery

Location Oakland, Md.

18. Funeral director Herbert E. Leighton

Address Oakland, Md.

19. Nov 22 1947 (Date rec'd by registrar) Hester L. Frantz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 21 1947 at 8:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Nov 1947 to 21 Nov 1947 and that I last saw h..l..n alive on 21 Nov 1947

Immediate cause of death	DURATION
Prematurity	
Due to 7 mo - Caesarean Section	
Due to Placental Abruption - Preeclampsia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dallas B. Hunt M.D. M. D. or other

Address 112 Bedford St. Date signed 22 Nov 47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

16a

Reg. Dist. No. 09635 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hours

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Fourth Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Margery Anne Kimberlin

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Newborn

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 3, 1947

8. AGE: Years | Months | Days | If less than one day: 12 hrs. 15 min.

9. Birthplace: Cumberland, Allegany, Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER — 12. Name: Glenn Eugene Kimberlin

FATHER — 13. Birthplace: Bedford Co. Pa

MOTHER — 14. Maiden name: Gertrude Lee Deming

MOTHER — 15. Birthplace: Bedford Co. Pa.

16. Informant: Mr. Glenn E. Kimberlin

Address: 15 4th St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 5, 1947 (month) (day) (year)

Cemetery or crematory: St. Thomas Cem.

Location: Bedford, Penna.

18. Funeral director: H. Wayne George

Address: Cumberland, Md.

19. Nov 4 1947 (Date rec'd by registrar) W.K. Fauntz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3 1947, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-3-1947, to 11-3 1947 and that I last saw h... alive on 11-3- 1947

Immediate cause of death	DURATION
atelectasis of both lungs	1/2 day
Due to congenital malformation	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operetinus: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cense tn which deeth should be charged stetistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L Bruns MD M. D. or other

Address: 59 Greene St. Date signed: 11-4-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09636

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town).

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred: 304 Independence St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 304 Independence St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Howard Knight

3. (b) Social Security Number: 214-05-6264

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mathilda Taylor

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 5 1879

8. AGE: Years	Months	Days	If less than one day
68	2	3	hrs. min.

9. Birthplace: Ridgley W Va. (Town, county, and state)

10. Usual occupation: Wholesale

11. Industry or business: grocery Business

FATHER — 12. Name: John Knight

13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Eliza Ellen Fisher

15. Birthplace: Md.

16. Informant: Jos. J. Knight

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 11, 1947 (month) (day) (year)

Cemetery or crematory: St Peter's + Paul's Cemetery

Location: Cumberland, Md.

18. Funeral director: Louis Stein Inc

Address: Cumberland Md.

19. Nov. 11, 1947 (Date rec'd by registrar) C. R. Fraley M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 1947 at 1.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-3- 1945 to 11-8- 1947

and that I last saw h... alive on 11-8- 1947

	DURATION
Immediate cause of death: Congestive heart failure	2 wks.
Due to: Chronic myocarditis	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. R. Fraley MD M. D. or other

Address: 54 Green St. Date signed 11-8-47

Dr Briggs

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09637

47c

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Ellmore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs
Hospital, Institution, or street address where death occurred: —
How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Allegany
City or town: Ellmore, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: George S Kroll

3.(b) Social Security Number: 179-03-4994

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Emma Kroll
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Jan. 16, 1876

8. AGE: Years: 71 | Months: 10 | Days: 6 | If less than one day: ... hrs. ... min.

9. Birthplace: Lonaconing, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Coal Miner Retired
11. Industry or business: Coal Mines
FATHER
12. Name: John Kroll
13. Birthplace: Germany
MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Lloyd Kroll
Address: Barton, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 25, 1947 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.
18. Funeral director: M. E. Richards
Address: Lonaconing, Md.
19. Nov 25 1947 (Date rec'd by registrar) Jannette M. Cool Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/22 1947 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/10 1947, to 11/22 1947 and that I last saw h. alive on 11/22 1947

Immediate cause of death	DURATION
Bronchogenic	
due to Carcinoma	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: — Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury — Injured at work?

23. SIGNATURE: Paul Eugene Frey, M.D. (M. D. or other)
Address: Lonaconing, Md. Date signed: 11/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits Dr. Faw

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4/6d

CERTIFICATE OF DEATH

09638

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 Years

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 93 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 411 Decatur Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Beatrice Kuhns

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Howard M. Kuhns

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) August 27, 1903

8. AGE: Years	Months	Days	If less than one day
44	3	3	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business ??

FATHER 12. Name W. F. Hiser

13. Birthplace Maryland

MOTHER 14. Maiden name Lillie M. Brant

15. Birthplace Maryland

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/3/47 (month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

18. Dec 5 1947 (Date rec'd by registrar) W. H. Fautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1947 at 8:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sep. 3 1947, to Nov. 30 1947 and that I last saw h alive on Nov 30 1947

Immediate cause of death	DURATION
1 ADENO-carcinoma rectum	1 yr.
2 Colitis, Suppurative, Chronic	12 yrs.
Due to 3 Pulmonary embolism	
Due to Coronaries	Nov. 30, 1947
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations adeno carcinoma rectum Date of op. Sep 6, 1947

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. M. Faw Jr M. D. (M. D. or other)

Address Cumberland, Md. Date signed Nov. 30, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Dr. Arthur Jones

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09639

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, Institution, or street address where death occurred:

Allegany County Infirmary

How long in hospital or institution? 22 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Mascan

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Price Lancaster

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Mary Hyde

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 1, 1880

8. AGE: Years	Months	Days	If less than one day
67	6	18	..... hrs. ..... min.

9. Birthplace Allegany Co. Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Thomas Lancaster

13. Birthplace Allegany Co., Md.

MOTHER 14. Maiden name Anna McKenzie

15. Birthplace Allegany Co., Md.

16. Informant Allegany County Infirmary

Address Cumberland, Md.

17. Burial Date thereof Nov. xx 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Alleg. Co. Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Nov. 22 1947 W. R. Trautz, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1947 at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1946 to Nov 19 1947 and that I last saw him alive on Nov. 15 1947

Immediate cause of death	DURATION
Myocardial failure	12 hrs
Due to Chronic myocarditis	5 yrs
Due to Generalized arteriosclerosis	25 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Arthur F. Jones M.D.

M. D. or other

Address 110 S. Centre St. Date signed 11-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits Yes

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d

09640

1454

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 Years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 950 Bedford St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Conda G. Lashley

3.(b) Social Security Number: 213-12-9734

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Virginia Orndorff Lashley

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): February 25 1884

8. AGE: Years	Months	Days	If less than one day
63	8	22	....hrs. ....min.

9. Birthplace: Elbinsville, Pa
(Town, county, and state)

10. Usual occupation: President

11. Industry or business: L & A Bus Lines Inc

FATHER 12. Name: Jacob H. Lashley

FATHER 13. Birthplace: Elbinsville, Pa

MOTHER 14. Maiden name: Nancy Bennett

MOTHER 15. Birthplace: Artemas, Pa.

16. Informant: Mrs Conda Lashley

Address: 930 Bedford St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 19, 1947 (month) (day) (year)

Cemetery or crematory: Hill Crest Burial Park

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Nov. 18 1947 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 17 1947, at 1-50 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 22 1947 to Nov 17 1947 and that I last saw him alive on Nov 16 1947

Immediate cause of death	DURATION
Chronic endocarditis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) .... (County) .... (State)

Injured at home, farm, industry, public place (where?) ....

Means of Injury .... Injured at work?

23. SIGNATURE: R. A. Trewaski, M. D. M. D. or other

Address: Cumberland, Md Date signed: Nov 17-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93c

09641

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 Years

Hospital, institution, or street address where death occurred:
146 Hanover Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 146 Hanover St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henrietta
Ella ~~Henrietta~~ Lewis

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Joshua Lewis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 21 1870

8. AGE: Years	Months	Days	If less than one day
76	11	12	..... hrs. ..... min.

9. Birthplace: Orleans, W.Va.
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: Solomon Rexroad
13. Birthplace: Orleans, W. Va.

MOTHER
14. Maiden name: Mary Wolf
15. Birthplace: Orleans, W. Va.

16. Informant: Mrs. Roger Eackles
Address: 146 Hanover St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 6, 1947 (month) (day) (year)

Cemetery or crematory: St Lukes Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Nov 6 19 47 W.R. Frantz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3, 1947 19 ..... at 11-30P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1945 19 ..... to Nov. 3, 19 47

and that I last saw h. alive on Nov. 3 19 47

Immediate cause of death	DURATION
Rheumatic cardio-muscular disease	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: D. B. Irons M.D.
M. D. or other

Address: Medical Bldg Date signed 11-4-47

Within corporate limits

DR COOPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

108

09642

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 22 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. BOWMANS ADDITION, R.F.D. #3
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ~~LAWRENCE DAVID LIVENGOOD~~ David Franklin Livingood

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	INFANT

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEPT 9, 1947

8. AGE: Years	Months	Days	If less than one day
~~2 MONTHS~~ 0	2	12	..... hrs. ..... min.

9. Birthplace CUMBERLAND MD
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name LAWRENCE LIVENGOO D
13. Birthplace MARYLAND

MOTHER
14. Maiden name WINEBRENNER MARY
15. Birthplace MARYLAND

16. Informant Lawrence Livingood

Address Rt. 3, Cumberland, Md

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof NOV 23 1947 (month) (day) (year)

Cemetery or crematory Davis Memorial Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Nov 22 47 (Date rec'd by registrar) Hunter R. Frank M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 21 19 47 at 8:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 Oct 19 47, to 21 Nov. 19 47

and that I last saw h.(im) alive on 21 Nov. 19 47

Immediate cause of death — DURATION

Unresolved pneumonia (left lower lobe, right upper lobe) — 33 days.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Unresolved Pneumonia.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. L. Cooper M. D.
M. D. or other

Address 122 S. Center St. Date signed 21 Nov 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 09643

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Yrs.

Hospital, institution, or street address where death occurred:
203 Greene St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 203 Greene St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Hamilton Longwell

3.(b) Social Security Number: 705-07-3507

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Teresa King Longwell

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): July 16, 1896

8. AGE: Years	Months	Days	If less than one day
51	3	25	hrs. min.

9. Birthplace: Manassas, Va.
(Town, county, and state)

10. Usual occupation: Supt. Of Shops

11. Industry or business: B. & O. Railroad Co.

FATHER
12. Name: William Marshall Longwell
13. Birthplace: Bellefonte, Penna.

MOTHER
14. Maiden name: Elizabeth Sinclair
15. Birthplace: Manassas, Va.

16. Informant: Mrs. Teresa Longwell
Address: 203 Greene St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 14, 1947 (month) (day) (year)

Cemetery or crematory: Masonic Mausoleum

Location: Clarksburg, W. Va.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Nov 13 1947 W. L. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 11, 1947 at 7:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-7- 1943 to 11-11-47 and that I last saw h... alive on 11-9-47

	DURATION
Immediate cause of death: Coronary Occlusion	Many Years
Due to: Coronary Arteriosclerosis	Years
Due to: Myocardial Degeneration	Years
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. L. Williams M. D. or other

Address: Cumberland Date signed: 11-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

Dr Moseley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09644 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or Institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie E. Malloy

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Lawrence L. Malloy

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 18, 1883

8. AGE: Years	Months	Days	If less than one day
64	1	20	hrs. min.

9. Birthplace: Mt. Savage Allegany Md

(Town, County, and State)

10. Usual occupation: housewife

11. Industry or business: home

FATHER

12. Name: Edward Wills

13. Birthplace: Mt. Savage Md.

MOTHER

14. Maiden name: Mary Ann Rohoff

15. Birthplace: Mt. Savage Md.

16. Informant: Joseph Malloy

Address: Mt. Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 11 1947 (month) (day) (year)

Cemetery or crematory: St Patricks

Location: Mt Savage Md

18. Funeral director: J. R. Durst

Address: Frostburg Md.

19. Nov 10 1947 (Date rec'd by registrar) W. R. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOVEMBER 8th 1947 at 2:00 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 - 1946 to Nov. 8th 1947

and that I last saw h... alive on November 8th 1947

Immediate cause of death: Myocarditis - acute dilatation Heart. Unknown to me - and

DURATION: Several years.

Due to:

Due to:

Other conditions: Diabetes -

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William E. Moseley M.D

M. D. or other

Address: Mt Savage Md Date signed 11/8-1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09645

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Rural Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo. 29 da.

Hospital, institution, or street address where death occurred:

Winchester Rd.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Winchester Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME: Paul Richard Smartz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 11 1947

8. AGE:

Years	Months	Days	If less than one day
	6	29	..... hrs. ..... min.

9. Birthplace: Cumberland Md.

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Julius Smartz

13. Birthplace: Md.

MOTHER

14. Maiden name: Anna Mary Casserly

15. Birthplace: Md.

16. Informant: Julius Smartz

Address: Winchester Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 - 11 - 47 (month) (day) (year)

Cemetery or crematory: St Ambrose Cem.

Location: Keyser W. Va.

18. Funeral director: Louis Stein Sons

Address: Cumberland Md.

19. 11-11-1947 (Date rec'd by registrar) M. K. Yarnall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 10 1947 at 6.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6 1947 to Nov. 10 1947 and that I last saw h... alive on November 8 1947

Immediate cause of death	DURATION
Bronchopneumonia	one week
Due to: pertussis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Elizabeth Briggs M.D.

M. D. or other

Address: La Vale Md. Date signed 11/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09646

Reg. Diat. No. .....

1. PLACE OF DEATH

County Allegany

City or town Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Alleg.

City or town Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Peter Martin Marty

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 11 1947

8. AGE: Years	Months	Days	If less than one day
	7	12	..... hrs. ..... min.

9. Birthplace Cumberland (Town, county, and state) Md

10. Usual occupation Cresaptown Md

11. Industry or business

FATHER

12. Name Julius W Marty

13. Birthplace Cresaptown Md

MOTHER

14. Maiden name Anna Casserly

15. Birthplace Cumberland Md.

16. Informant Julius W Marty

Address Cresaptown Md.

17. Burial Date thereof Nov. 25 1947 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Ambrose Cem

Location Cresaptown Md

18. Funeral director Davis Steed Sons

Address Cumberland Md.

19. 11 24 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 23 1947, at 10 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-23 1947, to 11-23 1947 and that I last saw h.i.m. alive on 11 22 1947

Immediate cause of death	DURATION
Bi Lateral Bronchial Pneumonia	3-4 days
Due to Pertussis O.I.C.	1 month
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE Wm H. McFarland M. D. or other

Address CRESAPTOWN Date signed 11-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09647

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 439 N. Centre St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 439 N. Centre St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna Mc Clure

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Robt. Mc Clure

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 14, 1873.

8. AGE: Years	Months	Days	If less than one day
74	1	0	..... hrs. ..... min.

9. Birthplace: ~~Ger~~ McKeesport Pa.

(City or town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Patrick Canaker

13. Birthplace: Penna.

MOTHER — 14. Maiden name: Mary Kilfoley

15. Birthplace: Penna

16. Informant: Mercedes Mc Clure

Address: 439 N. Centre St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/17/47 (month) (day) (year)

Cemetery or crematory: St Patricks

Location: Fairview Ave.

18. Funeral director: Louis Stein Inc.

Address: 117 Frederick St.

19. Nov 16 1947 (Date rec'd by registrar) W.R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14, 1947, at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-4- 1947 to 11-14 1947 and that I last saw h[illegible] alive on 11-13 1947

	DURATION
Immediate cause of death: congestive heart failure	3 weeks
Due to: chronic myocard'ts	6 months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W.R. Trautz M.D. M. D. or other

Address: 39 Greene St. Date signed 11-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124 b 09648

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town La Vale) Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town La Vale) Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rd #1
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Charles Leonard Mc Cormick

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6.(b) Name of husband or wife Anna Margaret Raer

6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Aug. 14- 1904

8. AGE: Years	Months	Days	If less than one day
43	2	23	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business Confectionary Store

FATHER
12. Name Joseph A. Mc Cormick
13. Birthplace Cumberland, Maryland

MOTHER
14. Maiden name Anna E. Miller
15. Birthplace Cumberland, Maryland

16. Informant Charles J. Mc Cormick
Address RD #1, Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof November 9, 1947 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Maryland

18. Funeral director John J. Hafer

Address Cumberland, Maryland

19. Nov. 8, 1947 (Date rec'd by registrar) Carl R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1947 at 8.35A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead Nov. 7 1947

Immediate cause of death	DURATION
Coronary occlusion	about 2 hours
Due to	
Due to	
Other conditions cirrhosis of the liver and edema of the legs. (Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V.Deming M.D. H.V.Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 11-7-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09649

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 Yrs 9 Days 1 Month

Hospital, Institution, or street address where death occurred:
100 West Second Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 100 West Second Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Alexander McCormick

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Miller McCormick

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): February 27 1877

8. AGE: Years	Months	Days	If less than one day
70	9	1	...hrs. ...min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Fuller Brush Company

FATHER
12. Name: John McCormick
13. Birthplace: Cumberland Md

MOTHER
14. Maiden name: Barbara Zink
15. Birthplace: Cumberland Md

16. Informant: Russell C. McCormick
Address: 100 West Second St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 30, 1947 (month) (day) (year)

Cemetery or crematory: St Lukes Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Nov. 29 19 47 (Date rec'd by registrar) Hunter A. Trenty M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1947, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19... and that I last saw h... alive on (Pronounced Dead) 19...

	DURATION
Immediate cause of death: Coronary Thrombosis	Sudden
Due to: Hypertension	2 yrs
Due to: Arteriosclerosis	2 yrs
Other conditions: Cerebral Hemorrhage	2 yrs. ?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Chas. L. Lewis M.D.

M. D. or other

Address: Cumberland Date signed 11/28/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 09650

CERTIFICATE OF DEATH

Reg. Diat. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Allegany
City or town Midland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DEACEASED: (For newborn infants give residence of mother)
State Maryland County Allegany
City or town Midland (If outside city or town limits, write RURAL and give nearest town)
Street No. — (If rural, give LOCATION)
2.(d) If veteran, name war —

3.(a) FULL NAME Mrs. Mary Stakem McGeady

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Michael A. McGeady
6.(c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months — | Days — | If less than one day ... hrs. ... min.

9. Birthplace Midland Allegany Co. Md. (Town, county, and state)
10. Usual occupation School teacher
11. Industry or business Allegany Co Public School

FATHER
12. Name Daniel Stakem
13. Birthplace Ireland

MOTHER
14. Maiden name Bridget Baynes
15. Birthplace Eichhorn

16. Informant Michael A. McGeady
Address Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 7 1947 (month) (day) (year)
Cemetery or crematory St. Michael's Cemetery
Location Frostburg, Md.

18. Funeral director J. L. Eichhorn
Address Lonaconing, Md.

19. Nov 7 1947 (Date rec'd by registrar) Jeanette M Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5th 1947, at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-5-47 19.. to 11-5-47 19..
and that I last saw her alive on 10-2-47 19..

	DURATION
Immediate cause of death Coronary occlusion	Seconds
Due to	
Due to	
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operation — Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. Z. Zimmerman M. D. or other
Address Cumberland Md. Date signed 11-6-47

Within corporate limits

09651

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany County Infirmary

How long in hospital or institution? 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Jane McKenna

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 23, 1861

8. AGE: Years	Months	Days	If less than one day
86	7	20	hrs. min.

9. Birthplace: Barton, Allegany County, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Patrick McKenna
13. Birthplace: Ireland

MOTHER
14. Maiden name: Catherine Conroy
15. Birthplace: Ireland

16. Informant: Allegany County Infirmary
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 15, 1947 (month) (day) (year)
Cemetery or crematory: St. Gabriel's Cem.
Location: Barton, Md.

18. Funeral director: Ellsworth S. Beal
Address: Westernport, Md.

19. Nov. 14, 1947 W. R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13, 1947 at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1946, to Nov. 13 1947 and that I last saw h.. alive on Nov. 12 1947

Immediate cause of death	Myocardial failure	DURATION 2 yrs
Due to	Chronic myocarditis	10 yrs
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 110 S. Centre St. Date signed 11-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09652

160c

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 139 W. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frederick McKenzie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) November 7 - 1947

8. AGE: Years	Months	Days	If less than one day
			3 hrs. ____ min.

9. Birthplace Md. Allegany Co. Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Frederick McKenzie

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Mabel Wilson

MOTHER 15. Birthplace Md.

16. Informant Frederick McKenzie

Address 139 W. Main St. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-8-47 (month) (day) (year)

Cemetery or crematory Jahnsonia Cemetery

Location Star Rt. Garrett Co. Frostburg Md.

18. Funeral director Frederick McKenzie

Address 139 W. Main St. Frostburg Md.

19. 11-8 1947 (Date rec'd by registrar) Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1947, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 7 1947 to Nov 7 1947

and that I last saw him alive on Nov 7 1947

	DURATION
Immediate cause of death Pneumonia Virus	
Due to Placenta Previa	2 days
Due to Caesarean Section	
Other conditions Hemorrhage	

(Include pregnancy within 3 months of death)

Major findings of operations Placenta torn loose around Cervix Date of op. Nov 7 47

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Alan G. Hunt M.D. M. D. or other

Address Cumberland Md. Date signed Nov 8 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Within corporate limits

DR. FAW
DR. NELSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83d 09653

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMROIAL HOSPITAL

How long in hospital or institution? 124 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town WESTERNPORT, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME JOHN B. MILLER

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife BERNICE RECKLEY MILLER

6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) JULY 1, 1893

8. AGE: Years 54 Months 4 Days 19 If less than one day ... hrs. ... min.

9. Birthplace Fayette County, [illegible] / Pennsylvania
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name CHARLES A. MILLER

13. Birthplace West Virginia

MOTHER 14. Maiden name Amanda Parsell

15. Birthplace West Virginia

16. Informant Memorial Hospital

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal) Which?) Date thereof Nov 23 1947 (month) (day) (year)

Cemetery or crematory Oakland

Location Oakland, Md.

18. Funeral director W Harold Fridlock

Address Piedmont. W.Va.

19. Nov. 22 1947 (Date rec'd by registrar) W.R. Fraunfelter, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 20, 1947 at 2:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1, 1947 to Nov 20 1947

and that I last saw him alive on Nov 20 1947

Immediate cause of death	DURATION
Paraplegia - injury to spinal cord 1918 - with ascending	1918
Due to urinary infection - Spontaneous Vesico - abdominal and Vesico - rectal	
Due to fistulae. Bilateral pyonephrosis. Fatal toxemia	2 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Skin Grafts to ulcerated skin surface Date of op. Oct 1, 1947

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 1918

Where did injury occur? Western Part allegany Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Mine

Means of injury Rocks slide in mine Injured at work? Yes.

23. SIGNATURE W W Faw Jr. M.D.
M. D. or other

Address Cumberland Md Date signed 11-22-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Jacobean 93d 09654

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 769 Fayette St

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 769 Fayette St. (If rural give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Israel Morgan

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married.

6.(b) Name of husband or wife Anna Cohen

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Apr 12, 1868

8. AGE: Years	Months	Days	If less than one day
79	7	12	hrs. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual occupation Merchant (Retired)

11. Industry or business Clothing Business

FATHER 12. Name Jacob Morgan

13. Birthplace Lithuania

MOTHER 14. Maiden name Celia Weiner

15. Birthplace Lithuania

16. Informant Nathan Morgan

Address 769 Fayette - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 26 1947 (month) (day) (year)

Cemetery or crematory East View Cemetery

Location Cumberland Md.

18. Funeral director John J Hafer

Address Cumberland Md.

19. Nov 26 1947 (Date rec'd by registrar) W.R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1947 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 14 1947 to Nov 24 1947 and that I last saw h... alive on Nov 19 1947

Immediate cause of death	DURATION
Acute Myocardial Failure	—
Due to Arteriosclerotic Heart disease & Myocardial deg.	?
Due to	
Other conditions Cerebral Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address [illegible] Date signed 11/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Please call
65 when
signed.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09655

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town 122 South Center St Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 122 South Center St. (Medical Bldg)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. Scotch Hill
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME J. Newton Morgan

3.(b) Social Security Number 216-05-5752

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1884

8. AGE: Years	Months	Days	If less than one day
63	4	19	hrs. min.

9. Birthplace Lonaconing, Md (Town, county, and state)
10. Usual occupation Blacksmith
11. Industry or business Coal Mines

FATHER
12. Name Esau Morgan
13. Birthplace England

MOTHER
14. Maiden name Rebecca Rinker
15. Birthplace Virginia

16. Informant Charles K. Morgan
Address Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 25 1947 (month) (day) (year)
Cemetery or crematory Oak Hill Cemme.
Location Lonaconing, Md
18. Funeral director Louis Stein, Inc.
Address Cumberland, Md

19. Nov 24 1947 (Date rec'd by registrar) W. A. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1947 at 4.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw him alive on Dead Nov. 21 1947

Immediate cause of death	DURATION
Ruptured aortic aneurysm, syphilitic [illegible]	at once
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. Examiner
Address Cumberland Md. Date signed 11-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09656

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs

Hospital, institution, or street address where death occurred 134 South St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 134 South St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph Alphonso Imullen

3. (b) Social Security Number 304-12-1057

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Widowed.

6.(b) Name of husband or wife Julia Griffin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 30 1869

8. AGE: Years 78 Months 4 Days 13 If less than one day ..... hrs. ..... min.

9. Birthplace Piedmont W. Va.

(Town, county, and state)

10. Usual occupation Ry. Trainman

11. Industry or business

FATHER 12. Name Edward Imullen

13. Birthplace Ireland

MOTHER 14. Maiden name Anastasia Kelley

15. Birthplace Md

16. Informant Mrs F. C. Homer

Address Cumberland

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Nov 15 47 (month) (day) (year)

Cemetery or crematory St. Patricks Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Nov 14 1947 (Date rec'd by registrar) W. R. Fauth, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1947 at 4P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1946, to Nov. 13, 1947, and that I last saw h[illegible] alive on Nov. 12, 1947.

	DURATION
Immediate cause of death Cerebral Haemorrhage	2 days
Due to Cerebral Arteriosclerosis	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Geo. F. Homer M. D. or other

Address Cumberland Date signed 11/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

CERTIFICATE OF DEATH

09657

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 608 Ann Place
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Loleda Ogdeen

3.(b) Social Security Number 232-36-5067

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21-1925

8. AGE: Years 22 | Months 5 | Days 7 | If less than one day hrs. min.

9. Birthplace Upshur Co., W.Va.
(Town, county, and state)

10. Usual occupation Waitress

11. Industry or business Restaurant

FATHER
12. Name Ray Ogden
13. Birthplace Randolph Co. W.Va.

MOTHER
14. Maiden name McWay
15. Birthplace W.Va.

16. Informant Rondolph Hunt Funeral Directors
Address Webster Springs, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 1, 1947 (month) (day) (year)

Cemetery or crematory Rock Care Cemetery

Location ~~Opt~~ Rock Care, W.Va.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Nov. 28, 1947 (Date rec'd by registrar) W.R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 19 47 at 6-35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... er alive Dead Nov. 28 19 47

Immediate cause of death	DURATION
Portal (atrophic) cirrhosis of the liver	?
also ascities & terminal endocarditis.	
Due to	
Other conditions Splenomegalia	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Deputy Medical Examiner Injured at work? Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 11-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MEDICAL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

09658

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural near Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt #2, Williams Road

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Walter Neville O'Neal

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Infant

6.(b) Name of husband or wife: ✓

6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): November 5, 1947

8. AGE:

Years	Months	Days	If less than one day
0	0	2	..... hrs. ..... min.

9. Birthplace: Rt #2 Wms. Road, Cumberland, Alleg. Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: John Calvin O'Neal

13. Birthplace: Broadtop City, Penna.

MOTHER

14. Maiden name: Pauline C. Flook

15. Birthplace: Hagerstown, Md.

16. Informant: John C. O'Neal

Address: Rt #2 Wms Rd., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 8, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. Nov. 8 19 47 H. R. Trautz, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7 19 47 at 11:30 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 6 19 47 to Nov. 7 19 47

and that I last saw h-- alive on Nov. 4 19 47

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. B. Lewis M.D. M. D. or other

Address: 133 Va Ave Date signed: 11-7-47

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09659

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ?

Hospital, Institution, or street address where death occurred: Allegany County Infirmary

How long in hospital or institution? 10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. # 220 North Lee Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edgar B. Patterson

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Aug 20, 1871

8. AGE: Years 76 | Months 2 | Days 19 | If less than one day ... hrs. ... min.

9. Birthplace Juanita County, Pa. (Town, county, and state) ?

10. Usual occupation ?

11. Industry or business

FATHER 12. Name James W. Patterson

13. Birthplace ?

MOTHER 14. Maiden name Maggie Lyon

15. Birthplace ?

16. Informant Allegany County Infirmary

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 12, 1947 (month) (day) (year)

Cemetery or crematory Allegany County Cemetery

Location Cumberland, Md.

18. Funeral director John J. Haley

Address Cumberland, Md.

19. Nov 11, 1947 (Date rec'd by registrar) W. R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 19 47 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 46 to Nov. 9 19 47

and that I last saw him alive on Nov. 8 19 47

Immediate cause of death	DURATION
Acute Myocardial failure	17 hrs.
Due to Chronic Myocarditis	6 yrs.
Due to Arteriosclerosis	6+ yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE Arthur F. Jones M.D. M. D. or other

Address 110 S. Centre St. Date signed 11-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09660

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Eckhart

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Eckhart

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hattie E. Porter

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ____ years

7. Birth data of deceased (mo., day, yr.) March 28 - 1875

8. AGE: Years 72 | Months 7 | Days 7 | If less than one day ____ hrs. ____ min.

9. Birthplace Eckhart - alleg - md. (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name George Porter

13. Birthplace Eckhart, Md.

MOTHER 14. Maiden name Helen N. Porter

15. Birthplace Pa

16. Informant Stanley Porter

Address Eckhart, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 7-1947 (month) (day) (year)

Cemetery or ~~crematory~~ Porter

Location Eckhart, Md.

18. Funeral director J. J. Durst

Address Frostburg Md.

19. 11-7 1947 Mrs. Nancy L. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1947, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 10 1947, to November 4 1947.

and that I last saw Pt alive on November 4 1947.

	DURATION
Immediate cause of death Chronic myocarditis	2 yrs.
Due to Secondary anemia	—
Due to	—
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operation ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE H. C. Diehl M. D. M. D. or other

Address Frostburg, Md. Date signed 11/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

L. Br. 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

51b

09661

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town R. D. #5 Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Wesley Porter.

3.(b) Social Security Number None

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife Rose I. Porter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 11 - 1863

8. AGE: Years	Months	Days	If less than one day
84	1	10	..... hrs. ..... min.

9. Birthplace Eckhart Mines Allegany Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business General Farming

FATHER 12. Name John S. Porter

FATHER 13. Birthplace Eckhart Md.

MOTHER 14. Maiden name Rebecca Porter

MOTHER 15. Birthplace Eckhart Md.

16. Informant Marshall Porter

Address R. D. #5 Cumberland

17. Burial Date thereof Nov 23 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location ~~Frostburg~~ Md

18. Funeral director John J. Hafer

Address Cumberland Md

19. Nov. 22 19 47 Walter L. Leatherman Registrar
(Date rec'd by registrar) M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 19 47 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19 19 47 to Nov. 21 19 47 and that I last saw h.. alive on Nov. 21 19 47

Immediate cause of death	DURATION
(a) Uremia	3 days
Due to (b) coma from the portal	1 yr.
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations cystotomy

on a female Date of op. 11-20-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. Wilson M.D.
M. D. or other

Address 59 Greene St. Date signed 11-24-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93c

09662

CERTIFICATE OF DEATH

Reg. Diat. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town near Mt. Savage Md. (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Vale Summitt
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Grace Pryle

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Micheal Pryle

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7th., I874

8. AGE: Years	Months	Days	If less than one day
73	6	I9	hrs. min.

9. Birthplace Vale Summit, Md.
(Town, county, and state)

10. Usual occupation House Work

11. Industry or business

FATHER 12. Name John Barber

13. Birthplace Scotland

MOTHER 14. Maiden name Janet Irving

15. Birthplace Scotland

16. Informant Mrs. John Bennette

Address Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof II/29/47 (month) (day) (year)

Cemetery or crematory Methodist Cem.

Location Vale Summit, Md.

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19. Nov 29 1947 (Date rec'd by Registrar) Vernina M Bennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 19 47 at 9.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... er alive Dead Nov. 25 19 47

Immediate cause of death	DURATION
Chronic rheumatic myocarditis	several years
Due to	
Due to	
Other conditions Hypertention due to arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. Other

Address Cumberland Md. Date signed 11-25-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

82

09663

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport - rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
2 mi so of Westernport

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport-rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 miles so of Westernport
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna Elizabeth Rembold

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femalr	White	Widow

6.(b) Name of husband or wife: Amos Rembold

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 29, ~~1878~~ 1879

8. AGE: Years 67 | Months 10 | Days 26 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Petersburg, Grant, W. Va.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own home

FATHER
12. Name: Moses Weese
13. Birthplace: not known

MOTHER
14. Maiden name: Mary Bensonhaver
15. Birthplace: not known

16. Informant: Carl Leatherman

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 28, 1947 (month) (day) (year)

Cemetery or crematory: ~~PRIVATE~~ Cemetery Queens Point

Location: Keyser, W. Va.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md.

19. Nov. 28 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 19 47 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 07 to Nov 25 19 47 and that I last saw h[illegible] alive on Nov 25 19 47

	DURATION
Immediate cause of death: Pulmonary Edema	6 days
Due to: Hypostatic Pneumonia	2 mo
Due to:	
Other conditions: Pulmonary Mycotic (Include pregnancy within 3 months of death)	3 yrs.

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or Coroner

Address: [illegible] Date signed: 11/28/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830 09664

Reg. Diat. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 93-0-18
Hospital, Institution, or street address where death occurred: Church Street
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. Church Street
(If rural, give LOCATION)
2.(a) If veteran, name war -

3.(a) FULL NAME Lydia Phillips Richards

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Anthony Richards
6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Oct. 24 1834

8. AGE:

Years	Months	Days	If less than one day
93	0	18	hrs. min.

9. Birthplace Lonaconing Allegany Co. Md
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business Own home
MOTHER FATHER
12. Name John Phillips
13. Birthplace Unknown
MOTHER
14. Maiden name Janet Ford
15. Birthplace Unknown
16. Informant Mrs. Mary Whitfield
Address Lonaconing Md
17. Burial Date thereof Nov 14 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Oak Hill Cemetery
Location Lonaconing, Md
18. Funeral director Dr. Eichhorn
Address Lonaconing, Md
19. Nov. 14 1947 Jeanette M Boal
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12, 1947 at 5.15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 22 1947 to Nov 11 1947
and that I last saw h alive on Nov 1st 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Henry M. Hodgson M.D.
M. D. or other
Address Lonaconing Md Date signed Nov 12 1947

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

09665

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 Years

Hospital, institution, or street address where death occurred:
115 Independence St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 Independence St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Susan Rizer

3.(b) Social Security Number: 129-03-3041

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry C. Rizer

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): May 24 1875

8. AGE: Years	Months	Days	If less than one day
72	5	19	..... hrs. ..... min.

9. Birthplace: Pleasant Valley, Bedford Co, Penna
(Town, county, and state)

10. Usual occupation: Rosenbaum Bros

11. Industry or business: Clerk

FATHER
12. Name: Alfred W. Rice
13. Birthplace: Plesant ValleyPa

MOTHER
14. Maiden name: Louvenia Tantlinger
15. Birthplace: Lone Tree, Lowa

16. Informant: Harry C. Rizer
Address: 115 Independence St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 16, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Nov. 16, 1947 (Date rec'd by registrar) W R Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13, 1947 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/13/47 19.. to 11/13/47 19..
and that I last saw h.. alive on 11/13/47 19..

Immediate cause of death	DURATION
Cerebral hemorrage	
Due to arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R Kerker M. D. or other

Address: 11/14/47 Cor Bedford St Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

838

09666

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. High Street
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Phoebe Eisentrout Roby

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ Edward Roby

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 21, 1869

8. AGE: Years	Months	Days	If less than one day
78	6	20	hrs. min.

9. Birthplace Barton, Md. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

MOTHER FATHER
12. Name Charles Eisentrout
13. Birthplace Germany
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mrs Charles Stewart
Address High St., Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 15, 1947 (month) (day) (year)
Cemetery or crematory Oak Hill Cemetery
Location Lonaconing, Md.

18. Funeral director W. J. Eichhorn
Address Lonaconing, Md.

19. Nov. 13 1947 (Date rec'd by registrar) Janette M Beal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 8 1947 to Nov 11 1947 and that I last saw h[illegible] alive on Nov 8 1947

Immediate cause of death	DURATION
Arteriosclerosis	1 yr.
Coronal thrombosis	1 wk.
Due to	
Due to	
Other conditions Senile dementia	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Norman Reese M.D.
M. D. or other
Address Westernport Md Date signed 11-12-47

VS A15 9-45-151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

09667

Reg. Diat. No. 5

1. PLACE OF DEATH:
County Allegany
City or town Cresaptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. Va. County Mineral
City or town Keyser
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Rufus Herman Rodruck

3.(b) Social Security Number 234 38 7804

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife Susan Mae Brown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 11th. 1873

8. AGE: Years	Months	Days	If less than one day
74	6	19	..... hrs. ..... min.

9. Birthplace Antioch, Mineral Co. W. Va.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Benjamin Thomas Rodruck
13. Birthplace Burlington, W.Va.
MOTHER 14. Maiden name Jane Elizabeth Fout
15. Birthplace Arthur, Grant Co. W. Va.
16. Informant Mrs. John Chaney
Address Cresaptown
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 2nd. 47 (month) (day) (year)
Cemetery or crematory Queenspoint
Location Keyser, W.Va.
18. Funeral director N.H.Rogers
Address Keyser, W.Va.
19. 12/2 1947 (Date rec'd by registrar) W. H. Trumbo Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30th. 1947 at 10. A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15, 1947 to Nov. 30. 1947
and that I last saw h.. alive on Nov. 24. 1947

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Arteriosclerosis of	
Coronary Arteries	
Due to Fatty degeneration	
Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE P. L. Dyer M.D. M. D. or other
Address Petersburg W.Va. Date signed 12-1-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157e

09668

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 9 hrs. 10 min.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town OAKLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war /

3.(a) FULL NAME SHAHAN BABY BOY

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCT. 26, 1947

8. AGE: Years	Months	Days	If less than one day
~~2 weeks~~		13	..... hrs. ..... min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name SHAHAN, ARRALY

13. Birthplace WEST VA.

MOTHER 14. Maiden name CALHOUN, VIOLA

15. Birthplace WEST VA.

16. Informant Arraly Shahan

Address Oakland. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 11-1947 (month) (day) (year)

Cemetery or crematory Oakland Md

Location Oakland Md

18. Funeral director Emery Bolden

Address Oakland Md

19. Nov. 11 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9th 1947, at 7.10 P.M.

21. I CERTIFY that death occurred ~~on the~~ date above stated; that I attended deceased from Nov 9th 1947, to Nov 9- 1947

and that I last saw him alive on Nov 9th 1947

Immediate cause of death	DURATION
Lipoid Pneumonia	
Due to Lipoid	3 days
Due to	
Other conditions Congenital Endocarditis	2 wks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE P. L. Owens M.D. M. D. or other

Address Cumberland Md Date signed Nov 9-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09669

93d

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Allegany

City or town Near Creaptown, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, Institution, or street address where death occurred:

Rt 5

How long in hospital or Institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Near Creaptown, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route # 5

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Charles Lupton Shanholtzer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Laura Arnold

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 14 1866

8. AGE: Years 81 | Months 7 | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace Augusta W. Va. (Town, county, and state)

10. Usual occupation Trackman (Retired)

11. Industry or business Rail way

FATHER 12. Name Isaac Shanholtzer

13. Birthplace W. Va.

MOTHER 14. Maiden name Emily Jane Oats

15. Birthplace W. Va

16. Informant Mrs Dewey Shepperd

Address Creaptown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 19 '47 (month) (day) (year)

Cemetery or crematory Augusta Cem.

Location Augusta W. Va.

18. Funeral director Louis Stein Inc

Address Cumberland

19. Nov. 17, 1947 (Date rec'd by registrar) W. F. Hammond Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1947, at 5 50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to Nov. 15 1947 and that I last saw him alive on Oct. 15 1947

Immediate cause of death	DURATION
Hypertension C.V.D. Arteriosclerosis	Years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE B. M. Schneider M.D. M. D. or other

Address 41 Greene St. Date signed Nov. 17 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr Schindler

TOPPER

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09670

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH.

County: ALLEGANY

City or town: CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 27 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: PA. County: BEDFORD

City or town: HYNDMAN Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Londonderry Township

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: SHROYER, EVELYN MISS

3. (b) Social Security Number: 213-24-5357

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 28 1922

8. AGE: Years	Months	Days	If less than one day
25	4	14	hrs. min.

9. Birthplace: PA. Hyndman Bedford Co. Pa. (Town, county, and state)

10. Usual occupation: ~~CELANESE~~ Employee

11. Industry or business: CELANESE Corp. of America

FATHER — 12. Name: SHROYER WALTER

FATHER — 13. Birthplace: PA.

MOTHER — 14. Maiden name: EMERICK BESSIE

MOTHER — 15. Birthplace: PA.

16. Informant: Walter Shroyer

Address: R.D. #1 Hyndman

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 26, 1947 (month) (day) (year)

Cemetery or crematory: Hyndman Comps.

Location: Londonderry Twp., Bedford Co.

18. Funeral director: H. H. Zeigler

Address: Hyndman, Pa.

19. Nov. 26 1947 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOVEMBER 22, 1947 at 10:15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 47 1947, to Nov 22 1947

and that I last saw h... alive on Nov 22 1947

Immediate cause of death: Aplastic Anemia — DURATION: Sub.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John A Topper MD M. D. or other

Address: Hyndman Pa. Date signed 11/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46 e

09671

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 yrs.
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 801 LAFAYETTE AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME GEORGE SMALLWOOD

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWER

6.(b) Name of husband or wife ANNA REESER
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MAY 1, 1875

8. AGE: Years	Months	Days	If less than one day
72	6	8	..... hrs. ..... min.

9. Birthplace VA. Loudoun County.
(Town, county, and state)
10. Usual occupation Janitor
11. Industry or business P & O — U.M.C.A.
FATHER 12. Name SMALLWOOD, ~~GEORGE~~ Franklin
13. Birthplace MARYLAND ~~Va~~
MOTHER 14. Maiden name Sara Virts
15. Birthplace Va.
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND
17. Burial Date thereof Nov 12 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Hillcrest Cemetery
Location Cumberland Md.
18. Funeral director John J. Haley
Address Cumberland Md.
19. Nov. 12 1947 W. K. Krantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 9, 1947 at 1:43 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2 1947 to November 9 1947 and that I last saw h[illegible] alive on November 9 1947

Immediate cause of death	DURATION
Carcinoma of sigmoid colon with metastasis to	
Due to liver	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of sigmoid colon with liver metastasis - advanced Date of op. Nov 7, 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Wyker M Faw M. D.
M. D. or other
Address 5 Washington St Cumberland Md. Date signed Nov. 9, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15 9-45-15M

✓Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09672

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 - 8-9

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 814 Stewart Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna Rose Smith

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Harry L Smith

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 6 1878

8. AGE:

Years	Months	Days	If less than one day
69	8	9	hrs. min.

9. Birthplace: Cumberland, Alleg Co., Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER

12. Name: Herman T Hirshmyer

13. Birthplace: Md

MOTHER

14. Maiden name: Caroline - Unknown

15. Birthplace: Md

16. Informant: Harry E Smith

Address: Cumberland

17. Burial, cremation, or removal. Which? Burial Date thereof: Nov 18, 47 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland

18. Funeral director: Louis Altieri Sons

Address: Cumberland

19. Nov. 17 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 15 1947 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1947, to Nov. 15, 1947, and that I last saw her alive on Nov. 15, 1947

Immediate cause of death	DURATION
Chronic myocarditis with Dilatation	10 mon.
Due to Uraemia	
Due to Diabetes Mellitus	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clay E. Jarrett M. D. or other

Address: Cumberland Date signed: 11/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46C

09673

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

145 Hanover St.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 145 Hanover St.,

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Annie Clorie Snyder

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Samuel Snyder

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Aug. 8, 1874

8. AGE: Years	Months	Days	If less than one day
73	2	23	....hrs. ....min.

9. Birthplace: Hancock, Washington, Maryland

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Jack Easton

13. Birthplace: Maryland

MOTHER

14. Maiden name: Catherine Scruble

15. Birthplace: Maryland

16. Informant: Mrs. Lucy Butler

Address: 145 Hanover St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 5, 1947 (month) (day) (year)

Cemetery or crematory: St. Peters Cem.

Location: Hancock, Md.

18. Funeral director: H. Wayne George

Address: Cumberland, Md.

19. Nov. 3 1947 (Date rec'd by registrar) W.R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 2, 1947, at 4:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-15 1947 to 11-2 1947

and that I last saw h... alive on 10-29 1947

Immediate cause of death: Coma & Ac Stomach — DURATION: 3 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. M. D. or other

Address: 54 Greene St. Date signed: 11-2-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09674

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital Cumberland Md.

How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 421 Homer St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Anzie Stafford

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 21, 1940

8. AGE: Years 7 | Months 4 | Days 9 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland Alleg Co. Md.
(Town, county, and state)

10. Usual occupation: student

11. Industry or business

FATHER
12. Name: John M. Stafford
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Norma Zinn
15. Birthplace: Myersdale Pa.

16. Informant: Mrs. Kenneth Chaney
Address: 421 Homer St. Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 2, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Hermon Cemetery
Location: near Cumberland Md.

18. Funeral director: John J. Hafer
Address: Cumberland Md.

19. Dec 2 1947 (Date rec'd by registrar) Wm. L. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 30 19 47 at 8.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw her alive Dead Nov. 30 19 47

Immediate cause of death: Diptheria — DURATION: about 1 week

Due to:

Due to:

Other conditions: no doctor

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V.Deming M.D. H. V. Deming M.D.
M. D. or other

Address: Cumberland Md. Date signed: 11-30-47

Within corporate limits Yes

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09675

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? lifetime

Hospital, institution, or street address where death occurred: 320 Baltimore Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 320 Baltimore Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Ella Frances Tritch

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ✓

6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): April 4 1862

8. AGE:

Years	Months	Days	If less than one day
85	7	21	hrs. min.

9. Birthplace: Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Retired Dressmaker

11. Industry or business

FATHER

12. Name: Henry Tritch

13. Birthplace: Cumberland, Md.

MOTHER

14. Maiden name: Unknown

15. Birthplace

16. Informant: Grace Wright

Address: 320 Baltimore Ave, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 28, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Maryland

18. Funeral director: John J. Hafer

Address: Cumberland, Maryland.

19. Nov 28, 1947 (Date rec'd by registrar) W. P. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 1947 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1, 1947 to Nov. 25 1947 and that I last saw her alive on Nov. 25, 1947

Immediate cause of death	DURATION
Pneumonia	14 days
Due to: Myocarditis	5 yrs
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Cayl Jones M. D. or other

Address: Cumberland Date signed: 11/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age if possible. Physicians: please write the causes of death clearly and legibly. This is especially important.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

09676

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, Institution, or street address where death occurred:
Memorial Hospital, Cumberland Md.

How long in hospital or institution? about 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 528 Maryland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ~~I World War~~

3.(a) FULL NAME: Raymond Kelly True

3.(b) Social Security Number: 705-09-9692

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Bertie Gordon

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): July 27 1882

8. AGE:

Years	Months	Days	If less than one day
53	4	—	...hrs. ...min.

9. Birthplace: Bucks Valley Pa.
(Town, county, and state)

10. Usual occupation: Car Repair helper

11. Industry or business: B.& O R.Ry.

FATHER
12. Name: Edw N. True
13. Birthplace: Pa.

MOTHER
14. Maiden name: Martha Garland
15. Birthplace: Pa.

16. Informant: Mrs Raymond K. True
Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 1 47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland. Md.

19. Dec 1 1947 (Date rec'd by registrar) W.R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27 19 47 at 1.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...
and that I last saw him alive Dead Nov. 27 19 47

Immediate cause of death	DURATION
Apoplexy, cerebral hemorrhage	about 18 hrs.
Due to: hypertention	about 1 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. (Coroner)

Address: Cumberland Md. Date signed 11-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09677

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1 South Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Lewis Valentine

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 6, 1947

8. AGE: Years	Months	Days	If less than one day
0	4	0	hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Lewis W. Valentine
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Virginia Wolford
15. Birthplace: Fort Ashby, W. Va.

16. Informant: Mr. Lewis Valentine
Address: 1 So. Terrace Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 8, 1947 (month) (day) (year)

Cemetery or crematory: Fort Ashby Cem.

Location: Fort Ashby, W. Va.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Nov. 8, 1947 (Date rec'd by registrar) C.R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 6, 1947, at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 6, 1947 to Nov. 6 1947 and that I last saw h... alive on Nov. 6 1947

Immediate cause of death	DURATION
Bronchopneumonia	
Due to Laryngotracheobronchitis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Elizabeth Gross M.D.
M. D. or other

Address: La Vale, Md. Date signed: 11/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

Zimmerman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46c

09678

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs

Hospital, institution, or street address where death occurred Allegany Hospital

How long in hospital or institution? 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1213 Virginia Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Gordon Wallis

3.(b) Social Security Number 217-10-7424

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Clara Willard

6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Apr 13, 1889

8. AGE: Years	Months	Days	If less than one day
58	6	29	...hrs. ...min.

9. Birthplace Shorton Ohio (Town, county, and state)

10. Usual occupation Power Clerk

11. Industry or business B & O. Railroad.

FATHER 12. Name Alonzo Wallis

13. Birthplace Ohio

MOTHER 14. Maiden name Mattie Willis

15. Birthplace Ohio

16. Informant Mrs Gordon Wallis

Address 1213 Va Ave Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 15 1947 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland Md

18. Funeral director John J Hafer

Address Cumberland Md

19. Nov 15 1947 W. L. Frantz, M.D. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1947 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 17, 1947 to Nov. 12 1947 and that I last saw h.. alive on Nov. 12 1947

Immediate cause of death	DURATION
Carcinoma of gall bladder + duodenum	6 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C C Zimmerman M.D.

Address Cumberland, Md M. D. or other Date signed 11-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS (A15) 9.45-15M

Within corporate limits

09679

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93 d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 216 Polk St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: May Evans Webster

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: G.W.F. Webster

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 31, 1877

8. AGE: Years	Months	Days	If less than one day
70	7	25	..... hrs. ..... min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Edward Evans
13. Birthplace: Wales

MOTHER
14. Maiden name: Elizabeth Jones
15. Birthplace: Wales

16. Informant: G. W. Francis Webster
Address: 17 Va. Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 28, 1947 (month) (day) (year)
Cemetery or crematory: HillCrest Burial Park
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Nov. 28 1947 (Date rec'd by registrar) Clark Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26, 1947 at 7:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946 to Nov. 26 1947 and that I last saw h... alive on Nov 26 1947

	DURATION
Immediate cause of death: Heart Block Myocarditis	months
Due to: Generalized arteriosclerosis	years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: B. M. Schmidlapp M. D. or other

Address: 41 Fremont Date signed: Nov 27 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

09680

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D of C County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1319 Park Rd N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Carlisle Lee Weisiger

3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Beatrice A —

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 17 1904

8. AGE:

Years	Months	Days	If less than one day
43	4	3	..... hrs. ..... min.

9. Birthplace: Richmond Va.

(Town, county, and state)

10. Usual occupation: Shop Insp.

11. Industry or business: Auto Co.

FATHER

12. Name: Percy L. Weisiger

13. Birthplace: Georgia

MOTHER

14. Maiden name: Jay Hancock

15. Birthplace: Va.

16. Informant: Mrs Dorothy Wood

Address: 2704 - 8th St. North Arlington Va

17. Burial: (Burial, cremation, or removal. Which?) Date thereof: 11-20-47 (month) (day) (year)

Cemetery or crematory: Washington D. C. Cem.

Location: Washington D. C.

18. Funeral director: The S.H. Hines Co.

Address: Washington D. C.

19. 11/20/ 1947 (Date rec'd by registrar) W.R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20 1947 at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/15 1947, to 11/20 1947, and that I last saw h(im/er) alive on 11/20/47 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John V. Rozum M.D. M. D. or other

Address: Cumberland Md Date signed: 11/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09681

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: 1203 Lexington Ave. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Twenty years

Hospital, institution, or street address where death occurred:
1203 Lexington Avenue

How long in hospital or institution? X

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1203 Lexington Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Mabel Welch

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Edward Welch

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): February 17-1891

8. AGE: Years: 56 | Months: ~~Feb.~~ 9 | Days: 12 | If less than one day: ....hrs. ....min.

9. Birthplace: Oakland Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: X

FATHER
12. Name: Upton Cuppett
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Elizabeth Welch
15. Birthplace: Unknown

16. Informant: Edward Welch
Address: 1203 Lexington Ave. City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 2, 1947 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Mt. Herman, Cumberland, Md.

18. Funeral director: John T. Welfard

Address: Cumberland Md.

19. Dec 1 1947 (Date rec'd by registrar) W.R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29 19 47 at 7.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....

and that I last saw her alive Dead Nov. 29 19 47

Immediate cause of death: Chronic Myocarditis — DURATION: several years

Due to:

Due to:

Other conditions: Hypostatic congestion of the lungs. — about 4 days
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Deputy Medical Examiner - Allegany Co Injured at work?

23. SIGNATURE: H.V. Deming M.D. H.V. Deming M.D. (M. or other)

Address: Cumberland Md. Date signed: 11-29-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09682

9

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo 6 days

Hospital, institution, or street address where death occurred: 616 Montreal Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 616 Montreal Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Dorothy Marie Hertz

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 19 '47

8. AGE: Years | Months: 2 | Days: 6 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland Md.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Floyd A Hertz

FATHER — 13. Birthplace: Pa.

MOTHER — 14. Maiden name: Norma Rinker

MOTHER — 15. Birthplace: Cumberland Md

16. Informant: Mr Floyd Hertz

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-26-47 (month) (day) (year)

Cemetery or crematory: St Marys Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Nov 26 1947 (Date rec'd by registrar) W. L. Fauntz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 1947 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10, 1947 to Nov. 25 1947 and that I last saw h[illegible] alive on Nov. 25, 1947

Immediate cause of death: Pertussis — DURATION 15 days

Due to: Cardiac Failure

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Mary E. Burnett M. D. or other

Address: Cumberland Date signed 11/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 09615

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Rawlings
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, Institution, or street address where death occurred:
Rawlings
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Rawlings
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Caleb James White

3.(b) Social Security Number 220-07-6070

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Mabel Armstrong
6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Aug 9 1888

8. AGE:

Years	Months	Days	If less than one day
59	3	18	..... hrs. ..... min.

9. Birthplace Job Randolph Co W. Va
(Town, county, and state)
10. Usual occupation Director
11. Industry or business Rent Control
FATHER 12. Name James Wm White
13. Birthplace Job W. Va.
MOTHER 14. Maiden name Ellen Nelson
15. Birthplace Franklin W. Va
16. Informant Mrs Caleb White
Address Rawlings Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 29 1947 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland Md.
18. Funeral director John J. Hafer
Address Cumberland Md
19. Nov. 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1947 at 4:45A m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to Nov 27 1947
and that I last saw h... alive on Nov 27 1947

Immediate cause of death Sudden - due to heart attack — DURATION
Due to Chr myocarditis — 5 years
Due to Cadiac Asthma — 6 mos
Due to —
Other conditions —
(Include pregnancy within 3 months of death)

Major findings of operation —
Date of op. —
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Cyrus R. Everhart M.D.
M. D. or other
Address 36 Greene St Date signed 11/29/47.

W.F. WILLIAMS

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09684

CERTIFICATE OF DEATH

638

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 521 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town LONACONING

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME WILHELM ADA E. MRS.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife WILHELM JOHN O.

DECEASED

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1876

8. AGE: Years	Months	Days	If less than one day
71	0	14	..... hrs. ..... min.

9. Birthplace MARYLAND Wilton Garrett Co.

(Town, county, and state)

10. Usual occupation HWIFE

11. Industry or business

FATHER

12. Name GARLITZ, NOAH

13. Birthplace MARYLAND, ~~Hancock~~ Wilton

MOTHER

14. Maiden name Mc KENZIE MARTHA

15. Birthplace MARYLAND Wilton

16. Informant Julius Wilhelm

Address R.D. Lonaconing

17. Burial Date thereof Nov. 24 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bloches Cem

Location Near Grantsville, Md

18. Funeral director Wm Winterberg

Address Grantsville, Md.

19. Nov 22 1947 W.F. Williams M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 20 1947 at 4:55P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 29 1947 to Nov. 20 1947

and that I last saw ... alive on Nov. 20 1947

Immediate cause of death	DURATION
Hyperthyroidism	
Due to Toxic Myocardial Degeneration	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.F. Williams M. D. or other

Address Grantsville, Md. Date signed 11-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. McLane 940 09685

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOHN EVAN WILLIAMS

3.(b) Social Security Number: 213-09-6550

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Regina Williams
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): May 11, 1889

8. AGE: Years	Months	Days	If less than one day
58	5	28	hrs. min.

9. Birthplace: Wales
(Town, county, and state)
10. Usual occupation: Silk worker
11. Industry or business: Celanese Corporation
FATHER 12. Name: Jenkin Williams,
13. Birthplace: Wales
MOTHER 14. Maiden name: unknown
15. Birthplace: "
16. Informant: Mrs. Regina Williams,
Address: Eckhart, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 12, 1947 (month) (day) (year)
Cemetery or crematory: St. Michael's
Location: Frostburg, Md.
18. Funeral director: J. R. Durst,
Address: Frostburg, Md.
19. 11-11 (Date rec'd by registrar) 1947 Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 9 1947 at 3:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 9 1947 to Nov 9 1947 and that I last saw him alive on Nov 9 1947

Immediate cause of death	DURATION
Coronary Thrombosis	5 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. O. McLane MD M. D. or other
Address: Frostburg Md Date signed 11-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09686

940

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Big Lane, Midland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Midland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Big Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Wm. Williams

3.(b) Social Security Number [illegible]

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of ~~husband~~ or wife Lydia P. Walker Williams

6.(c) If alive, give age [illegible] years

7. Birth date of deceased (mo., day, yr.) Feb. 23- 1871

8. AGE: Years	Months	Days	If less than one day
76	8	20	hrs. min.

9. Birthplace Mt. Savage, Allegany Co., Md
(Town, county, and state)

10. Usual occupation retired Switch Tender

11. Industry or business B & O. R. R Co

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Wm. R. Stevens
Address Midland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 16, 1947 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Maryland

18. Funeral director Wm. Eichhorn

Address Frostburg, Md.

19. Nov 15 1947 (Date rec'd by registrar) Johnette M. Boor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1947 at about 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 19 to 19

and that I last saw him alive Dead Nov. 13 1947

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 11-13-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55 C

CERTIFICATE OF DEATH

09687

Reg. Diat. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 63 Yrs 11 Mo 4 Days

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 6 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 630 Bedford St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Jo Wolfe

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frederick Wolfe

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): December 5 1883

8. AGE: Years	Months	Days	If less than one day
63	11	4	...hrs. ...min.

9. Birthplace: Cumberland, Allegany Co, Maryland (Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER

12. Name: Conrad Wagner

13. Birthplace: ~~Switzerland~~ Switzerland

MOTHER

14. Maiden name: Elizabeth Wilt

15. Birthplace: Holland

16. Informant: Mrs. Hazel Soethe

Address: 630 Bedford St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/13/47 (month) (day) (year)

Cemetery or crematory: Hill Crest Burial Park

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Nov 12, 1947 Wd. Trauty, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9 1947, at 6-30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15, 1947 to Nov. 9th 1947 and that I last saw h... alive on 11-9-47

Immediate cause of death	DURATION
Carcinoma Thyroid	2 yrs ?
Due to —	
Due to —	
Other conditions Diabetes Mellitus	6 mos ?

(Include pregnancy within 3 months of death)

Major findings of operations: degenerated material

Date of op. 10-1-47

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. Zimmerman M. D. or other

Address: Cumberland, Md. Date signed 11-9-47